

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC SAFETY
STATE ATHLETIC COMMISSION

PLEASE SUBMIT APPLICATION TO:
ONE ASHBURTON PLACE, ROOM 1301, BOSTON, MASSACHUSETTS 02108

APPLICATION FOR FIGHTER'S LICENSE

(Please Type or Print Legibly)
(Illegible or incomplete applications will not be accepted)

☐ BOXING

☐ MMA

☐ UNARMED COMBATANT: _____

☐ PROFESSIONAL

☐ AMATEUR

BACKGROUND INFORMATION

NAME _____
First Middle Initial Last

ADDRESS _____
Street City State Zip

DAYTIME TELEPHONE # (_____) _____ SOCIAL SECURITY # _____

DATE OF BIRTH ____/____/____ PLACE OF BIRTH _____

E-MAIL ADDRESS _____ OCCUPATION _____

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____
Street City State Zip

EMPLOYER'S TELEPHONE # (_____) _____

HEIGHT _____ PRESENT WEIGHT _____

AMATEUR RECORD _____ PROFESSIONAL RECORD _____

NAME AND ADDRESS OF TRAINER _____

DO YOU PRESENTLY SUFFER FROM ANY KNOWN MEDICAL CONDITION THAT WOULD MAKE IT UNSAFE FOR YOU
TO ENGAGE IN AN UNARMED COMBATIVE SPORTING EVENT? ☐ YES ☐ NO

HAVE YOU EVER BEEN HOSPITALIZED DUE TO AN UNARMED COMBAT RELATED INJURY? IF YES, PLEASE ATTACH
A WRITTEN EXPLANATION. ☐ YES ☐ NO



THE FOLLOWING ITEMS MUST ACCOMPANY THIS APPLICATION

(check box indicating compliance):

- ☐ \$75 application fee for professional fighters (no fee for amateur fighters until further notice)
- ☐ two passport photographs (2" x 2" in size) of the applicant's head (without headwear)
(unless MA-RMV Release signed off below)
- ☐ copy of a government issued photo identification (e.g.- driver's license)
- ☐ copy of birth certificate
- ☐ Record of Medical Examination form completed by examining physician within 30 days of date Of submission of this application. The medical records reviewed by physician must be attached to the form and submitted with this application. The medical records must include evidence of the following examinations: physical, HIV, Hepatitis BsAG, Hepatitis Cab, EKG, dilated eye exam, and (for renewals of a license) CT, MRI or neurological exam performed by a neurologist or neurosurgeon. All exams must have been performed within 30 days of the date of the review by the physician completing the Record of Medical Examination form.
- ☐ (for fighters who have never been licensed in Massachusetts) Debut Form

AUTHORIZATION FOR RELEASE OF RMV INFORMATION

My signature below authorizes the Department of Public Safety to electronically access my photograph from the Massachusetts Registry of Motor Vehicles database solely for use on this license/registration.

MA- RMV photo release signature

ATTESTATION

I hereby attest, under the pains and penalties of perjury, that the information provided above is true and accurate to the best of my knowledge. Further, I certify that I have filed all required tax returns and paid all state taxes as required by law.

Signature of applicant

Date

FOR COMMISSION USE ONLY

DATE OF COMMISSION REVIEW: _____

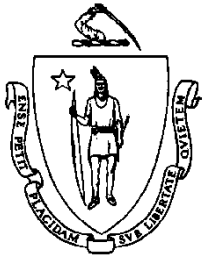
APPROVED _____ DENIED _____

DATE LICENSE MAILED: _____

REASON FOR DENIAL:

Rev. 4/11





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RECORD OF MEDICAL EXAMINATION
(MUST BE COMPLETED WITHIN THIRTY DAYS OF
SUBMISSION OF APPLICATION FOR LICENSURE)

BACKGROUND

FIGHTER'S NAME: _____ FIGHTER'S D/O/B: _____
DATE OF EXAMINATION: _____ HEIGHT: _____ WEIGHT: _____
NAME OF EXAMINING PHYSICIAN: _____
ADDRESS OF PHYSICIAN: _____
TELEPHONE # OF PHYSICIAN: _____
STATE IN WHICH PHYSICIAN IS LICENSED TO PRACTICE MEDICINE: _____

INSTRUCTIONS

All applicants for licensure as an unarmed combatant in Massachusetts must undergo a complete physical examination, including neurological and cardiac testing, by a licensed physician. The examination must include a review by the physician of the medical records identified below. Applicants should be in excellent health at the time of the examination in order for the examining physician to approve of licensing the individual. This form must be completed by the examining physician and given to the applicant so that it may be submitted to the Commission along with their application for licensure as an unarmed combatant. The physical examination and corresponding review of medical documentation may not take place more than thirty days prior to the submission of an application.

MEDICAL HISTORY

Has this individual ever suffered a concussion? ☐ YES ☐ NO

If yes, please provide date(s) and circumstances: _____

Does this individual wear contact lenses? ☐ YES ☐ NO

Has this individual undergone LASIK eye surgery? ☐ YES ☐ NO

(If yes, clearance to fight must be obtained from an optometrist or ophthalmologist prior to licensure.)

Please identify any present medical issues or past conditions you believe the Commission should be aware of in determining whether to license this individual as a professional combatant:

REVIEW OF MEDICAL RECORDS

The examining physician must review the records identified below and check the box indicating that the review has been performed. Please ensure that the examinations were performed within **30 days** of the review. The reviewing physician must be left satisfied that the records are authentic. The reviewed medical records must be attached to this form and submitted to the Commission.

- ☐ RECORD OF PHYSICAL EXAMINATION PERFORMED IN CONJUNCTION WITH THIS REVIEW
- ☐ EVIDENCE OF AN ASYMPTOMATIC ELECTROCARDIOGRAM (EKG) WITHIN **30 DAYS** PRECEDING THE DATE OF THE EXAMINATION
- ☐ EVIDENCE OF A NEGATIVE TEST FOR HIV, HEPATITIS BsAG, AND HEPATITIS CAB WITHIN **30 DAYS** PRECEDING THE DATE OF THE EXAMINATION
- ☐ EVIDENCE OF AN ASYMPTOMATIC DILATED EYE EXAMINATION BY AN OPTOMETRIST OR OPHTHALMOLOGIST WITHIN **30 DAYS** PRECEDING THE DATE OF THE EXAMINATION
- ☐ (IF APPLICABLE) (NOT REQUIRED FOR INDIVIDUALS APPLYING FOR AN AMATEUR LICENSE) EVIDENCE OF AN ASYMPTOMATIC BRAIN CT, BRAIN MRI, OR NEUROLOGICAL EXAMINATION PERFORMED BY A NEUROLOGIST OR NEUROSURGEON WITHIN **5 YEARS** PRECEDING THE DATE OF EXAMINATION

PHYSICIAN ATTESTATION

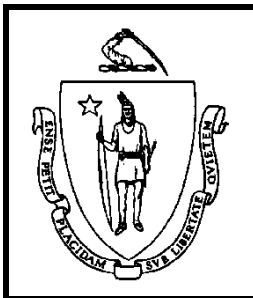
I hereby attest that I have examined the above named individual and reviewed all of the medical records identified above. I am aware that this individual seeks to be licensed as an unarmed combatant. In my medical opinion this individual does not suffer from any known conditions which should prevent them from competing and is otherwise presently fit to be licensed as an unarmed combatant.

NAME OF PHYSICIAN (PRINT)

SIGNATURE OF PHYSICIAN

DATE





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DEBUT IN MASSACHUSETTS FORM

BIOGRAPHICAL INFORMATION

NAME OF FIGHTER: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

HEIGHT: _____ PRESENT WEIGHT: _____

HOME ADDRESS: _____

AMATEUR RECORD: _____ PROFESSIONAL RECORD: _____

NAME AND ADDRESS OF TRAINER: _____

SPORT FOR WHICH YOU ARE SEEKING LICENSURE: ☐ BOXING ☐ MMA ☐ UNARMED COMBATANT

DISCIPLINE: _____

EXPERIENCE

AMATEUR RECORD: _____ ☐ ATTACH RESULTS LIST OF ALL AMATEUR FIGHTS

PROFESSIONAL RECORD: _____ ☐ ATTACH RESULTS LIST OF ALL PRO FIGHTS

-OTHER STATES IN WHICH YOU HAVE BEEN LICENSED: _____

LENGTH OF TRAINING PERIOD FOR PRESENT MATCH: _____

NAME AND ADDRESS OF TRAINER: _____

NAME AND ADDRESS OF MANAGER (IF ANY): _____

NAME AND ADDRESS OF PRIMARY TRAINING GYM: _____

(FOR MMA FIGHTERS) TEAM: _____

PRIMARY DISCIPLINE: _____



ATTESTATION

TWO INDIVIDUALS WITH PERSONAL KNOWLEDGE MUST ATTEST AS TO THE FITNESS OF THE FIGHTER TO PARTICIPATE IN A MATCH BY COMPLETING THE SECTION BELOW. ONE OF THESE INDIVIDUALS MUST BE THE FIGHTER'S TRAINER.

1. I, _____, HEREBY SWEAR OR ATTEST UNDER THE PAINS AND PENALTIES OF PERJURY THAT IN MY OPINION THE ABOVE NAMED FIGHTER HAS THE NECESSARY SKILLS AND IS OTHERWISE FIT TO COMPETE IN A PROFESSIONAL _____ MATCH.

(INSERT SPORT)

-RELATIONSHIP TO FIGHTER: **TRAINER**

-MA TRAINER'S LICENSE#: _____

-LENGTH OF TIME KNOWN FIGHTER: _____

-PHONE #: (____) _____

-EMAIL: _____

-ADDRESS: _____

SIGNATURE

DATE

2. I, _____, HEREBY SWEAR OR ATTEST UNDER THE PAINS AND PENALTIES OF PERJURY THAT IN MY OPINION THE ABOVE NAMED FIGHTER HAS THE NECESSARY SKILLS AND IS OTHERWISE FIT TO COMPETE IN A PROFESSIONAL _____ MATCH.

(INSERT SPORT)

-RELATIONSHIP TO FIGHTER: _____

-MA TRAINER'S LICENSE#: _____

-LENGTH OF TIME KNOWN FIGHTER: _____

-PHONE #: (____) _____

-EMAIL: _____

-ADDRESS: _____

SIGNATURE

DATE

